

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

14247

JUN 24 1927

1. PLACE OF DEATH

County..... **Buchanan**
 Township.....
 City..... **St. Joseph,** (No. **1214, 4th. Ave.**)

Registration District No. **85**
 Primary Registration District No. **1001**

File No.....
 Registered No. **538**
 St. Ward

2. FULL NAME

Jennie L. Clinkenbeard

(a) Residence, No. St. Ward.
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred **46** yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **William T. Clinkenbeard**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Mar, 9, 1881**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	46	2	10	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... **At Home.**
 (b) General nature of industry, business, or establishment in which employed (or employer).....
 (c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)..... **St. Joseph, Mo.**
 (STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER **Paschal Miller**

11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... **W. Virginia**
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER **Mary C. Hebron**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... **Marietta, Ohio.**
 (STATE OR COUNTRY)

14. INFORMANT **Wm. T. Clinkenbeard**
 (Address) **1214, 4th. Ave.**

15. FILED **31** 19 **27**
John G. Galt REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **May, 19, 1927**

17. I HEREBY CERTIFY, That I attended deceased from **Sept. 10, 1926** to **May 19, 1927**, that I last saw him **alive on May 19, 1927**, and that death occurred, on the date stated above, at **7.45 P.M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

93C
III B
Chronic myocarditis
 (duration) **4** yrs. mos. da.

CONTRIBUTORY **Odium of lungs**
 (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED **NO**
 IF NOT AT PLACE OF BIRTH

DID AN OPERATION PRECEDE DEATH? **NO** DATE OF

WAS THERE AN AUTOPSY? **NO**

WHAT TEST CONFIRMED DIAGNOSIS **Chronic findings**
 (Signed) **M. H. White**, M. D.

5/19, 1927 (Address) **307 Paul Kelly**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Mt. Auburn Cemetery** DATE OF BURIAL **May, 21, 1927**

20. UNDERTAKER **Walter Meierhoffer** ADDRESS **1302 Farson St.**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

